THE CHILDREN'S SLEEP LABORATORY

Tel # 407-898-2767 Fax # 407-898-9443

PatientName
Nombre del Paciente _____

Date of BirthFechade nacimiento _____

Date of StudyDia delEstudio _____

PrimaryPhysicianMedico de cabecera _____

ReferringPhysician
Medico que refirió _____

You/your child have been scheduled for an overnight sleep study at the Children's Sleep Lab located at the address of the above. Upon your arrival, you may find the doors to the building locked, please utilize the notification button to the right of the door if present at the lab where you are scheduled
.

If the doors are locked or if you need to call the local lab, after 8:00PM you may call: (407) 898-2767

We will make every attempt to confirm your appointment approximately 2-3 days in advance. Please be sure to call **407-898-2767** and **confirm your appointment at least 24 hours in advance**. If the appointment is not confirmed *within 24 hours*, **it may be cancelled**. If the appointment is scheduled on the weekend the study must be cancelled by Friday at 3:00pm.

ONLY One parent/legal guardian can and must stay with the patient for the duration of study.

INSTRUCTIONS TO FOLLOW THE DAY OF YOUR TEST

1. Arrive at 8:00 p.m.**(not arrive before 8:00pm)**
2. Please arrive with clean hair and body.
   (Do not use oils, hair spray, gels, lotion, etc.)
3. Bring something to sleep in:
   Two pieces of clothing preferably
   Tops should fit tightly or if possible, tank tops
4. Bring a pair of socks for children.
5. Take all routine medications unless otherwise instructed.
6. Eat dinner prior to coming for your sleep study.
7. Each room has cable TV however you may bring special booksor games if you prefer.

We will not be held responsible for any personal items brought with you.

*Please be sure to bring a photo I.D., any applicable insurance card(s) and if you have not paid your co-pay/deductible/coinsurance, please **be prepared to pay it upon arrival**. We accept cash, checks, debit, HRA and credit cards with the Visa or MasterCard logo as forms of payment.*

WHAT TO EXPECT

After arriving and settling in several wires will be attached to your head, chest and face. These monitor brain waves, breathing, oxygen levels and heart rate. During the test, the technician will be documenting the patients sleep stage, position and vital signs. Should the patient need to use the restroom during the night, push the call button and the technician will assist you immediately by disconnecting the main cable so that they may use our restroom.

You should be ready to leave by *approximately*5:00 a.m. the following morning. For your convenience we have full bathrooms with bathing facilities (some locations); we do not provide towels or toiletries so if you should require them please make sure to bring them with you. Should you require a work/school note, please let our staff know in advance and we will be happy to provide one. If you have additional questions, please feel free to call our staff @ (407)898-2767 or (866)-383-0556Monday through Friday between the hours of 9:00 a.m. and 4:00 p.m.

****As a pulmonary practice we have a STRICT NO SMOKING policy in/on and around our facilities for all staff and guests. Please do not smoke in, on or around our facilities. We ask if for any reason that you smell smoke on your technician(s) or see your technician(s) smoking that you IMMEDIATELY call (321)303-0069 or (407)924-9727.****

PLEASE ensure that your follow up appointment after your sleep study has been scheduled. Yoursleep study report cannot be finalized until the office visit has been completed.Child must accompany you on follow up visit.

The Children's Sleep Laboratory

2660 W. Fairbanks Avenue, Winter Park, FL32789 - Phone 407-898-2767 - Fax 407-898-9443
www.childrensleeplab.com

Patient Information

Date/Fecha: _____

Name / Nombre _____ Sex / Sexo **M or F** DOB / Fechanac _____

Social Security # / Numero Social _____ Phone / Telefono _____ Cell: _____

Address / Direccion _____ City / Ciudad _____ Zip / Numero Postal _____

PCP / Medico de cabezera _____ Phone/Fax / Telefono y fax _____ Referredby PCP? / Fue referido por doctor primario yes☐ no ☐

ReferringPhysician / Medico que referio _____ Phone/Fax / Telefono y fax _____

Reason for appt. / Razon por cita _____ How did you hear about us? / Comoescucho de nosotros _____

Guarantor/Legal Guardian Information

Name / Nombre _____ DOB / Fechanac _____ SSN / NumeroSocial _____ Relationship / Relacion al paciente _____

EmployerName / Nombre de Empleo _____ Employer Address / Direccion de Empleo _____

EmployerPhone / Telefono de Empleo _____ Email Address/Mande un correo electrónico dirección _____

Medical InsuranceInformation/Informacion del seguro

Primary Insurance / Seguro primario _____ Phone/Telefono _____

ID#: _____ Group #/Groupo _____

Claims Address / Direccion del seguro _____ City/St./Zip / Ciudad/Estado/Numero Postal _____

Secondary Insurance / Seguro Secundario _____ Secondary ID# _____

Failure to provide complete insurance information may result in patient responsibility for the entire bill.

BESIDES PARENTS
Person to Contact In Case of Emergency/Contacto de Emergencia

Name(s) / Nombre _____ Relationship / Relacion al Paciente _____

Telephone #'s / Telefono _____

It is our company policy to file your insurance claims. However, it is <u>your responsibility</u> to supply us with the accurate information. We *will not be responsible* for how your insurance carrier processes your claim so please ensure that you are fully aware of your individual plan requirements, limitations and benefits.

Como cortesía nuestra practica mandara a cobrar a su seguro. Pero es su responsabilidad darnos los datos correctos y más recientes. Es su responsabilidad saber su plan y sus limitaciones con su compañía de seguro.

CONSENT FOR PROCEDURE: There is typically no pain associated with a sleep study. Patients are shown to their room and asked to get ready for bed. Multiple electrodes are then attached to the following parts of the body: scalp (with specially formulated glue), underside of the chin and the lower portion of each leg in order to appropriately record the necessary data for the study. Two elastic like bands are placed around the chest and abdomen area that record breathing. An oxygen level sensor is placed on one finger and patches are applied to the chest to record the heartbeat. Upon completion of the study the electrodes are removed with a solvent and the majority of glue residue is cleaned out of the hair. Any remaining glue will wash out after a few shampoos. There *may* be some mild discomfort with the electrodes removal; patients with sensitive skin may have some irritation.

HIPAA ACKNOWLEDGEMENT: Our notice of privacy practices provides information about how we use and release protected health information about you. You have the right to review our notice before signing the form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front office staff.You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and release of protected health information about you for treatment, payment and healthcare operations as described in our notice. You have the right to revoke this consent in writing except where we have already made releases in reliance on your prior consent.

MAINTENANCE OF ELECTRONIC RECORDS AND SIGNATURES: Central Florida Pediatric Sleep Disorders Institute PA maintains all its medical records and patient information in an electronic database. If you do not understand the above statements please ask staff to explain prior to your approval. Please note that this document will be scanned and included in the medical records.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: It is company policy to file your claim with your insurance company however, any account balances due to co-pays, coinsurances or deductibles are your responsibility. In the event that we are not contracted or if your insurance company, through no fault of ours, refuses to pay our contracted or billed fees then you will be fully responsible. All payments are due within 15 business days of the date on your statement, if not paid within the allotted timeframe you *may* incur a finance charge. If you choose to leave less than 5 hours into the study you will be responsible for payment in full as this is less than the acceptable time for billing your insurance carrier.

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CANCELLATION AND NO SHOW FEES/NOTICE: Failure to cancel an appointment within 24 hours will result in a $250.00 no show fee that will be charged directly to you.

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS: Our office maintains the right to use your medical records/information for the purpose of treatment, payment and healthcare operation as deemed necessary. Records will be sent to other physicians directly involved in the care of the patient when appropriate. If there are any individuals, or entities that you specifically DO NOT want to have access to this information please inform us.

By signing below I acknowledge that I have read, understand and agree to abide with the above statements, including acknowledging that I am *fully* responsible for any monetary debts due on this account. My signature represents that I am voluntarily entering into a legal and binding contract for services with Children's Lung, Asthma & Sleep Specialists.

By signing below I am acknowledging and consenting to the assessment and treatment by Children's Lung, Asthma & Sleep Specialists providers which may include *Akinyemi Ajayi, MD, D,ABSM; Shivani Verma, MD; MaryAliceLeinbach, MSN, CPNP, ARNP and/or Kimberly K. Justice, Ph.D, CBSM, Lic. Psychologist,* for either myself and/or my minor child.

_____ _____

Printed Patient Name/ DOB**Signature** of Patient **(If not a minor)**
Nombre de paciente

_____ _____

Printed Name of Legal GuardianDOB**Signature** of Legal Guardian

_____

Date Signed

PATIENT QUESTIONNAIRE

Please complete the following: If needed, please use extra paper to comment.

Name/Nombre: _____ **Date of Birth/FechaNac:** _____ **Today's Date:**_____

Additional Information:

☐Down Syndrome/Síndrome de Down

☐ Autistic/ Autismo

☐ExcessiveDaytimeSleepiness
Sueno excesivo durante el día

☐FeedingTube/ Tubo de Alimentación

☐RestlessSleep/ Dormir sin descanso

☐ CPAP ☐ BiPAP Titration

☐Irregular Heart Rhythms/Ritmo del Corazón irregular

☐ ADD/ADHD/TDAH/TDAD

☐ Seizures/Convulsiones

☐Trach. Tube/ Tubo de Tráquea

☐ Other Medical/Mental Health Conditions / Otras Condiciones medicas/ psicologicas_____

1. What is the main reason for coming to the sleep lab?/ Razon por cita? _____
2. How long have the symptoms been present?/ Cuanto tiempo lleva con los síntomas? _____
3. Have you received treatment in the past for the symptoms?/ Ha recibido tratamiento en el pasado por los síntomas? _____
4. How many hours of sleep do you usually get per night?
   Cuantas horas duerme cada noche? _____
5. Have the present symptoms been continuous or intermittent?
   Síntomas son constantemente o intermitente?_____
6. Do any other family members have this problem?
   Historia familiar con el mismo problema?_____
7. How would you describe the sleep problem?
   Marque losproblemasapropiados. (check all that apply)
   _____ Wake up during the night/Despiertadurante la noche
   _____ Difficulty falling asleep
   Dificultades quedándose dormido
   _____ Excessivedaytimesleepiness
   Sueno excesivo durante el día
   _____ Difficultyawakening/Dificultades despertandose
8. What treatment has been received for this problem?
   Que tramítenos ha recibido por el problema?
   _____
9. What time do you/A qué hora se:
   gotobed/acuesta?_____
   wake up/despierta? _____
10. How long does it take to fall asleep?
    Cuanto se demora en quedarse dormido/a?_____
11. How many times do you wake up at night?
    Cuantas veces se despierta en la noche?_____
12. If you wake up at night, which part of your sleep period is it?
    En cual parte de la noche se despierta?
    _____soon after fallingasleep
    rápido después de quedarse dormido
    _____ in the middle of the night
    en la media noche
    _____ earlymorning
    temprano en la madrugada
13. If you wake up, how long do you stay awake?
    Si se despierta cuanto tiempo se queda despierto? _____

RATE HOW OFTEN THE FOLLOWING OCCURS:	CONSTANT*CONSTANTE*	FREQUENTLY*FREQUENTE*	SOMETIMES *ALGUNAS VECES*	BARELY*CASI NUNCA*	NEVER*NUNCA*
Wake up suddenly gasping for breath Se despierta de repente por falta de aire					
Snore/ Ronca					
Wake up at night with heartburn Se despierta con acides en el estomago					
Wake up coughing or wheezing/Se despiertatosiendo					
Disturbs others when snoring Despierta a otroscuandoronca					
Difficulty breathing at night Dificultadesrespirandocuandoduerme					
During the night has irregular heartbeat/ Tiene palpitacionesirregularesdelcorazon cuando duerme					
Feel refreshed upon awakening/Se despiertaalerto					
Daytime fatigue ortiredness/ Se siente cansadoa durante el día					
Fall asleep when laughing or crying se queda dormido/a cuando se ríe o llora					
Sleepinessaffectsworkorschool Se queda dormidoa en la escuela o en el trabajo					
Unable to move when waking up or falling asleep No puede moverse al acostar o despertar					
Has nightmares/ tienepesadillas					
Remembersdreams/ Se recuerda sus suenos					
Kicks during the night/Mueve sus piernas al dormir					
Feels anxious, sad or depressed Se siente ansioso, triste o deprimido					
Achingfeelings in legs/ Siente dolor en las piernas					
Discomfort during the night Incomodidaddurante la noche					

Morningjawpain/ Dolor en la mandíbula					
Grindteethduringsleep Chasquear los dientes por la noche					

THE EPWORTH SLEEPINESS SCALE

Please complete the following:

Name/Nombre: _____ Date of Birth/FechaNac: _____ Today's Date:_____

How likely are you to doze off or fall asleep in the following situations in contrast to feeling tired? This should be based on your current lifestyle. Use the following scale to choose the most appropriate number for each situation:

Necesitamos saber las probabilidades siguientes durante situaciones normales, no cuando el /la paciente este extremadamente cansado. Use la tabla siguiente para determinar sus respuestas:

0 = wouldneverdoze/nunca se queda dormido/a
1 = slight chance ofdozing/probablemente se quede dormido/a
2 = moderate chance ofdozing/más seguro que se quede dormido/a
3 = high chance of dozing/se quedadormido

Situation:	**Chance of dozing**
▪ Sitting and reading (leyendo)	_____
▪ Lying down in the afternoon (acostadoen la tarde)	_____
▪ Sitting and talking with someone(hablando con alguien)	_____
▪ Sitting quietly after lunch (despues de almorzar)	_____
▪ In a car, while stopped for traffic(sentadoentrafico)	_____
▪ Watching TV(mirando television)	_____
▪ Sitting inactive in a public place(sentado solo/a en sitios publicos)	_____
▪ As a passenger in a car for an hour without a break (Cuando es pasajero/a en un carro después de 1 hora)	_____
	TOTAL: _____

SLEEP BEHAVIORS SCREENER

1. Does your child have difficulty falling asleep?	☐ **YES** ☐ **NO**
2. Does your child have difficulty staying asleep?	☐ **YES** ☐ **NO**
3. Do you need to be present to help your child fall asleep at bedtime or return to sleep in the middle of the night?	☐ **YES** ☐ **NO**
4. Does your child fall asleep in places other than their own bed?	☐ **YES** ☐ **NO**
5. Do you feel your child has anxiety or fears that prevents them from falling asleep or staying asleep?	☐ **YES** ☐ **NO**
6. Does your child require TV, movies, DVD's or other electronics to fall asleep or stay asleep?	☐ **YES** ☐ **NO**
7. Does your child have disruptive behaviors such as impulsivity, hyperactivity, or difficulty focusing or concentrating?	☐ **YES** ☐ **NO**

TOTAL # YES:_____

The Children's Sleep Laboratory

Your appointment is on / / at 8pm at our _____office, and your
Follow up appointment will be on / / at _____.

Please make sure to bring your child to both appointments

If you need to cancel your appointment, you will have to call 407-898-2767 by_____between the hours of 8:30am-5pm (Monday-Friday) or as **soon as possible** in order to avoid a *No Show/Late Cancellation Fee*.**Failure to call/notify the facility will result in a *$250 charge that you will be responsible for*, since this will be the cost to have the sleep technician at the lab.**

Sleep Studies are from 8PM TO 6:00PM,If you are being picked up Please make arrangements to be picked up before 6AM, the office will close at 6AM

Thank you,
The Scheduling Staff

Your child has been scheduled for an overnight sleep study at the Children's Sleep Lab located at the address below.If **you need to call the lab, after 8:00PM you may call: (407) 898-2767. Select Option 1 or select the extension for the sleep lab location below.**

Winter Park (EXT 111) MAIN OFFICE
2660 W. Fairbanks Avenue Winter Park, FL 32789
Upon your arrival, you may find the doors to the building locked, please utilize the notification button to the right of the door

Hunter's Creek (EXT 144)
4151 Hunter's Park Lane Suite 108
Orlando, FL 32837

Lakeland (EXT 145)
2104 N Lakeland Hill Blvd
Lakeland, FL 33805

Melbourne (EXT 141)
8061 Spyglass Hill Rd Suite 103
Melbourne Fl 32940

Tampa (EXT 146)
16606 N. Dale Mabry Hwy
Tampa, FL 33618

Habana (EXT 137)
4700 N. Habana Ave Suite 200
Tampa, Fl 33614

Daytona (EXT 147)
533 N, Clyde Morris Blvd Suite C
Daytona Beach, FL 32114

East Orlando (EXT 136)
11317 Lake Underhill, Suite 300
, Orlando, Fl, 32825

New Port Richey (EXT 243)
3539 Little Rd
Trinity, Fl 34655

Leesburg (EXT 142)
101 South 11th ST Suite 1
Leesburg, FL 34748

Ocala (EXT 241)
2930 SE 3rd Ct Bldg 1
Ocala, FL 34471

Port Saint Lucie (EXT 139)
561 NW Lake Whitney Place Suite 101
Port Saint Lucie, FL 34986

Lake Park (EXT 150)
500 US-1
Lake Park, FL 33403

ONLY ONE parent/legal guardian can and must stay with the patient for the duration of study.

*********Please complete this form and bring to the scheduled appointment. **********

Patient Name: _____ **DOB**: _____Age: _____years /months

Primary Care/Referring Physician Name:

_____

Other Specialist or Physician Names:

_____

Please list any/all medications ***(including over the counter)*** that the patient is currently taking:_____

_____

Allergies*(Medication/food/environmental)*:_____

Has the patient had any allergy testing? ____YES ____NO If so, when: _____ how: Blood / Skin test
Has your child had any X-rays/ CT scans or MRI's: ____YES ____NO If so, when: _____
Results: _____

Describe in your words the symptom(s) he/she is having:_____

_____

_____

BIRTH HISTORY:

Birth weight: _____lbs _____oz. Length: _____in. Was the patient full term: ____YES ____NO
If no, how early: _____ Vaginal or c-section:_____

PROBLEMS WITH PREGNANCY: Y___ N___(if yes, please explain):_____

FEEDING HISTORY:

Breast milk / Formula, If formula, name and how long: _____
Current diet and food restrictions: _____
Does the patient have any problems with coughing, gagging, or choking while eating: ____YES ____NO
Does the patient have any problems with spitting up, vomiting, or stomach-aches: ____YES ____NO

GROWTH & DEVELOPMENT:

Has the patient ever had/do they currently have any of the growth/development issues listed below: ____YES ____NO

A) Motor skills (i.e. crawling, walking, running, playing): ____YES ____NO
If so, please list: _____
B) Sensory/communication (i.e. vision, hearing, speech): ____YES ____NO
If so, please list: _____
C) Weight or height: ____YES ____NO
If so, please list: _____

MEDICAL HISTORY:

Hospitalization(s): ____YES ____NO **Surgeries:** ____YES ____NO

Please provide detailed information, such as dates and reasons:

_____

_____

SLEEP HISTORY:

Does your child:

: snore? ____YES ____NO If yes, nights per week:_____, Howlong: _____years/months
: have difficulty falling asleep?____YES ____NO
: wake up a lot at night? ____YES ____NO : sleep too much? ____YES ____NO
: appearrestlesswhile sleeping? ____YES ____NO: appearrestlessbefore sleeping? ____YES____NO
: fall asleep in school? ____YES ____NO : wake up screaming, crying or sleep walking? ____YES____NO
: have behavioral issues, learning problems or trouble with concentrating and focusing? ____YES____NO

What time does your child:

Go to bed? _____ Go to sleep?_____Wake up (school days?)_____ (weekends?)_____
Does your child wake up in the middle of the night? ____YES ____NO
If so when and how often?_____
Any family history of sleep disorders? ____YES ____NO. If yes explain?_____

Patient Name: _____ **DOB**: _____

Has the patient ever had/do they currently have any issues listed below:

Eyes ____YES ____NO Ears ____YES ____NO Nose ____YES ____NO
Throat ____YES ____NO Kidney ____YES ____NO Joints/Bones ____YES ____NO
Seizures____YES ____NO Behavior ____YES ____NO Skin ____YES ____NO
Bowel/Bladder ____YES ____NO Heart ____YES ____NO Blood Pressure ____YES ____NO

IMMUNIZATIONS:

Are immunization shots up to date:____YES ____NO TB test: ____YES ____NO PPD/Tine:____YES ____NO
Has the patient ever tested posted for TB or had a positive PPD reading: ____YES ____NO

FAMILY HISTORY:

Has/have any of your immediate family members been diagnosed with any of the following:

		Relation to pt:			*Relation to pt*:
Apnea	____YES ____NO	_____	Asthma	____YES ____NO	_____
Bronchitis	____YES ____NO	_____	Chronic Cough	____YES ____NO	_____
SIDS/crib death	____YES ____NO	_____	TB	____YES ____NO	_____
Cystic Fibrosis	____YES ____NO	_____	Pneumonia	____YES ____NO	_____
Emphysema	____YES ____NO	_____	Hay Fever	____YES ____NO	_____
Sickle Cell/Anemia	____YES ____NO	_____	Sarcoidosis	____YES ____NO	_____

ENVIRONMENTAL/SOCIAL:

Mother's Name: _____ Father's Name: _____
Do you reside in a house/apartment/mobile home/other: _____
How many people live in the home: _____
Are there sibling(s) who attend school or daycare: ____YES ____NO.
Please list their age and their relationship to the patient:
_____
_____
Does anyone smoke in the residence: ____YES ____NO
Do you have pets: ____YES ____NO Are pets allowed in patient's room: ____YES ____NO
If so, what kind: _____
Is there a history of mold or exposure to mold in the household? ____YES ____NO
Is there a history of exposure to mold at school? ____YES ____NO

Residential Information:

A) How old is the residence: _____
B) How long have you lived there: _____
C) What type of heat/cooling system does it have: _____
D) Any fans (both ceiling and/or portable): ____YES ____NO How many: _____
E) How much dust accumulates: ____Minimal ____Moderate ____Heavy
F) Please list all flooring you have(i.e. tile, wood, laminate, carpet): _____
G) Is there carpet in the bedrooms:____YES ____NO
H) Does the patient:_____Have his/her Own Room ____ Share a Room
I) Are there stuffed animals/ pillows in the patient's room: ____YES ____NO

School & Sports Information:

A) Does the patient attend: ____School ____Daycare ____Before/After School Care
B) What grade is the patient in: _____
C) How many days have been missed due to illnesses this year: _____
D) Presently how would you rate their performance in school: ____Poor ____Average ____Above Average
E) How often does the patient have gym class: _____
F) Does the patient play any sports: ____YES ____NO
G) How does he/she interact & get along with other children: ____Poor ____Average ____Above Average
H) Does the patient make friends easily: ____YES ____NO

_____ _____
Print name and relationship to patient Date

_____ _____
Signature of Parent/GuardianDate

PEDIATRIC SLEEP SCREENER

THE EPWORTH SLEEPINESS SCALE (ESS-CHAD)

Please complete the following:

How likely are you to fall asleep in the following situations, in contrast to feeling tired? This should be based on your usual way of life at the present time. Even if you have not done some of these things recently, try to work out how they may affect you. Use the following scale to choose the most appropriate number for each situation:

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

Situation: Chance of falling asleep

- ✦ Sitting and reading ☐
- ✦ Sitting and watching TV or a video ☐
- ✦ Sitting in a classroom at school during the morning ☐
- ✦ Sitting and riding in a car or bus for about a half hour ☐
- ✦ Lying down to rest or nap in the afternoon ☐
- ✦ Sitting and talking to someone
- ✦ Sitting quietly by yourself after lunch ☐
- ✦ Sitting and eating a meal ☐

TOTAL: ☐

If your total score is above 9 talk to your doctor or go to a sleep specialist for further evaluation of excessive sleepiness.

KID'S SLEEP SCREENING QUESTIONNAIRE (KSSQ)

- Does your child snore? (Y)/(N)
- Is your child a restless sleeper? (Y)/(N)
- Does your child have difficulty falling asleep? (Y)/(N)
- Does your child sleep too much? (Y)/(N)
- Does your child fall asleep in school? (Y)/(N)
- Does you child wake up a lot at night? (Y)/(N)
- Does your child wake up screaming, crying or sleep walking? (Y)/(N)
- Does your child have behavioral concerns, learning problems or trouble with concentrating and focusing? (Y)/(N)

If you answered yes on more than 1 question go to a sleep specialist for further evaluation.

Kid's Sleep Screening Questionnaire

The questionnaire is an all encompassing sleep screening tool. It screens for pediatric sleep disorders in a variety of sleep categories and is useful across all pediatric age groups above 6 months of age.

Although answering any of the questions as a YES could suggest the presence of a sleep disorder, answering 2 or more of the questions as a YES would suggest the need for closer scrutiny which should may include further questions from the care provider.

Questions:

- "**Does your child snore?"** screens for sleep disordered breathing such as primary snoring, obstructive sleep apnea, central apnea and allergic rhinitis
- **"Is your child a restless sleeper?"** screens for movement disorders in sleep like restless leg syndrome, periodic limb movement in sleep and sleep disordered breathing related conditions with associated arousals, such as obstructive sleep apnea syndrome.
- **"Does your child have difficulty falling asleep?"** This screens for insomnia in its various forms including sleep resistance, behavioral insomnia of childhood, anxiety related sleep disorders and psychophysiologic insomnia
- **"Does your child sleep too much?"** This screens for excessive daytime sleepiness which can manifest in conditions such as narcolepsy and idiopathic hypersomnia or can be related to conditions with insufficient nighttime sleep or poor quality sleep as may be seen in obstructive sleep apnea syndrome, periodic limb movement in sleep and RLS
- **"Does your child fall asleep in school?"** This suggests abnormal/excessive sleepiness in a child and can be related to conditions including narcolepsy, insufficient sleep, sleep apnea or sleep fragmentation related to sleep apnea, periodic limb movement in sleep and nocturnal seizures
- **"Does your child wake up a lot at night?"** This screens for sleep parasomnias, nocturnal asthma, gastroeophageal reflux disease, periodic limb movement in sleep and sleep disordered breathing
- **"Does your child wake up screaming, crying or sleepwalking?"** This screens for sleep parasomnias such as night terrors, confusional arousals and sleepwalking
- **"Does your child have behavioral concerns, learning problems or trouble with concentrating and focusing?"** This questions looks into the neurocognitive and neurobehavioral implications of poor sleep regardless of the cause of the poor sleep. The known manifestations include hyperactivity, impulsiveness, poor focusing and decreased executive functioning and learning.